

***LOUISIANA STATE BOARD OF MEDICAL EXAMINERS
(LSBME)***

Main Phone: (504) 568-6820 (auto attendant)



PODIATRISTS

APPLICATION AND INSTRUCTIONS

(Rev. 080106)

Visit the LSBME website at www.lsbme.louisiana.gov

Application Processing Address:

LSBME, P.O. Box 54403, New Orleans, LA 70154-4403

Criminal Background Check Address:

LSBME, ATTN.: CB, P. O. Box 30250, New Orleans, LA 70190-0250

Physical Address:

630 Camp Street, New Orleans, LA 70130



PLEASE READ FIRST

The Louisiana State Board of Medical Examiners (the “Board”) annually processes hundreds of applications for licensure. This process involves the collection of credentials from the applicant as well as other sources. The Board conducts a thorough evaluation of credentials, employment or work history, malpractice history and disciplinary history. This process takes time - anywhere from a few weeks to several months, depending upon how quickly the applicant complies with what is requested and the nature of any problems requiring closer attention. Licensure is not guaranteed. As such, each applicant is advised not to make commitments on loans, practice start dates, home purchases, etc. The Board will not accelerate one application at the expense of another nor will it waive any requirements in the screening process. Once the application is received and reviewed, the analyst prepares and sends out a missing document report to request additional information and/or to return items that need corrections or clarifications. Please wait at least thirty days before calling to check on the status of the application. The Board has no control over materials that must be requested from other agencies. The Board shall have a reasonable period of time to collect and assimilate all required documents and information necessary to issue a license. If after submitting an application for licensure, an applicant has failed to respond or make an effort to pursue licensure for a period of six months, the application will be null and void and the applicant must reapply. If you have been named in a malpractice suit, been sanctioned by another state or agency or have answered “yes” to any of the questions on the oath and affirmation page of the application, you must provide a detailed notarized narrative of the incident and anticipate a delay in the licensing process. This includes offenses that may have occurred as a juvenile and that may have been expunged from your record. The criminal background check can take months to process. As such, it is suggested that you request the criminal background materials as soon as you know that you are relocating to Louisiana.

Qualifications for Licensure – Podiatry

- ◆ Be at least twenty-one years of age;
- ◆ Be a citizen of the United States;
- ◆ Be of good moral character;
- ◆ Present a diploma or certificate of graduation from a school or college of podiatry approved by the Louisiana State Board of Medical Examiners;
- ◆ Pass an examination from the Board that shall be written, oral or clinical or any combination thereof as determined by the Board. The required examination is the PMLexis.

Instructions for Completing the Application

Page 1

Licensure Category- Indicate your licensure category.

Address - Indicate your current Business, Home, and Preferred Mailing Address. (The Business address will appear on our website at www.lsbme.louisiana.gov).

Specialty- List specialties and board certifications.

Identification- Answer all identification questions.

Personal Interview - Board members are located throughout the state, indicate which city you would prefer to make the personal appearance.

Page 2

Statement of Legal Name - Record your name as it appears on each document listed that applies to you. This form must also be completed by any person whose name is not the same as the name on the diploma received from the professional school. This form must be notarized.

Page 3

Premedical/professional Education - List your education. Account for all time from high school to the present.

Professional Education - List the professional education - the place where you received your Medical/Osteopathic/Podiatry Degree. List all professional schools attended in chronological order.

Postgraduate Training - List all postgraduate training done in the United States or Canada in chronological order.

Practice History and Non-Professional Activities - List the practice history and non-medical/professional related activities here. Do not include training.

Examination History - Indicate the examination taken, number of attempts, and the state for which the examination was taken. List all that apply. There is a limit on the number of times an applicant can take the examinations. The limit applies whether the examination was taken in Louisiana or in another state.

Page 4

Unusual Circumstances.- List any unusual circumstances that may have occurred during college, medical/professional school, or post graduate training .

Page 5

Third Party Authorization- Read and have this form notarized.

Page 6

Oath or Affirmation - Read, answer and have this form notarized. Any “yes” answer(s) must be accompanied by a notarized affidavit. The applicant must explain in detail the incident(s) in which he/she is answering yes to and have the explanation typed written and notarized. This includes offenses that may have occurred as a juvenile and that may have been expunged from your record.

Page 7

Certificate of Dean/Registrar/Program Head/Chairman - Complete the top section and attach a photograph. The photograph must be notarized and signed as stated on form. After completing the required sections, mail it to the professional/medical/osteopathic school for completion.

Page 8

Verification of Internship or Equivalent Program - Applicant must complete the top section and mail it to their internship program for completion.

Page 9

Verification/Endorsement - If you named any state (including District of Columbia, Puerto Rico, Guam, Canada) on page 3 of the application, send a copy of this form to each of those states for completion whether the license issued was permanent, temporary or is now expired. It is suggested that you contact each state to inquire as to whether or not that state has any requirements that must be fulfilled before it will complete our form. Most states charge a fee and will not complete the form until that fee is paid. You may make as many machine copies of this form as is necessary.

Character Recommendation(s) - One for Podiatry from physicians/podiatrist other than relatives attesting to the applicants' good moral character and who have known the applicant for at least six months prior to filing the application.

GENERAL INSTRUCTIONS

The state of Louisiana does criminal background checks as part of the application process through the state (Louisiana Department of Public Safety and Corrections (DOC) and Federal Bureau of Investigations (FBI). Materials for this purpose can be obtained by writing to:

LSBME
Attn: CB
P O Box 30250
New Orleans, LA 70190-0250

or by e-mail at lsbmemat@lsbme.louisiana.gov

Applicants with criminal history may expect delays in the application process

Notarized Birth Certificate - The applicant must submit a notarized copy of the birth certificate or a notarized copy of the passport (expired passports are acceptable). If the applicant submits a passport, the applicant must include a written explanation of the reason the birth certificate is not available.

Valid Visa - Applicants who are not native-born citizens of the United States must show proof of legal entry into the United States to work or reside by presenting:

- ◆ Original Certificate of Naturalization
- ◆ Birth Certificate establishing birth to U.S. citizens traveling abroad
- ◆ Valid Visa issued by the Department of Immigration and Naturalization (INS)

Personal Appearance - Applicants should contact this office regarding the personal appearance. Appointments will only be scheduled after receipt of **ALL** application materials. At the time of the personal appearance, the applicant must present the **ORIGINAL** of the following documents (copies should have already been provided). All documents required to be presented must be in English. If the document(s) is not in English, they must be accompanied by a translation into English certified by a translator other than the applicant who shall attest to the accuracy of such translation under penalty of the law.

- ◆ Professional school diploma with English translation.
- ◆ Marriage license and/or court decree of the applicant who applies in a name different from the name on the medical diploma.
- ◆ If not a native born citizen of the United States, you must present a Certificate of Naturalization, a birth certificate identifying you as having been born to American parents while abroad or a valid visa which allows you to work and reside in the United States.

FEES ARE NOT REFUNDABLE and must accompany the application - \$300.00 for Podiatry – (additional \$100.00 if applying for a temporary permit). It should be noted that should the check be returned for any reason, you will be required to resubmit the fee in the form of a money order and there will be an additional charge of \$23.00.

Contact Addresses

The Chauncey Group International
664 Rosedale Road
Princeton, NJ 08540-2218
(609) 720-6500

FREQUENTLY ASKED QUESTIONS



Q. How long does the application process take?

A. The initial application process could take anywhere from a few weeks to several months to complete. Once the file is complete, it must be presented to the board for final consideration. Once a decision is made, the applicant is notified by mail within a week to ten days.

Q. How is the application processed?

A. Applications are processed in the order in which they are received. One application is not given priority over another.

Q. What is the deadline for the application to be presented to the Board for consideration?

A. The deadline is two weeks prior to a scheduled meeting. The application must be complete in every respect in order to be presented. If not, the application will have to wait until the next meeting. Board meetings are not held in the months of April and November.

Q. I need a license immediately. How can you help me?

A. Applications are processed on a first come first serve basis.

Q. Can I be issued a temporary permit to do residency/fellowship training?

A. Yes. The state of Louisiana does issue a permit for training purposes only.

Q. I am completing my internship/residency in June. How soon can I apply for a permanent license?

A. A U.S./Canadian graduate may apply for licensure four months prior to completion of the internship/residency.

Q. I have decided not to relocate to Louisiana. Can I withdraw my application? Is the fee refundable?

A. To withdraw an application, you must notify the Board in writing. No fees are refundable.

Q. What does "primary source verification" mean?

A. The term means that all information is received directly from the issuing agency.

Q. Can I practice in Louisiana with a license from another state?

A. Not unless you are practicing in a federal institution or military base.

Q. What fees are involved in the application process?

A. There is a non-refundable license fee of \$300.00 (Podiatry) made payable to the Louisiana State Board of Medical Examiners and must accompany your application. A \$50.00 **money order** is required for the criminal background check. The money order is made payable to the Department of Public Safety and Corrections.

Q. How many attempts are allowed on PMLexis?

A. Four

Q. If I have had my fingerprints cleared by another state or agency, will Louisiana accept them?

A. No.

Q. Do I need to send my ORIGINAL or a notarized copy of my documents with the application?

A. No. A copy of the aforementioned documents should be submitted with your application. All original documents are presented at the personal appearance.

Q. Can a family member, friend, spouse or telephone call take the place of appearing in person for the interview?

A. No.

Q. I have a license in another state. Do I have to go through the application process again?

A. Yes.

LOUISIANA STATE BOARD OF MEDICAL EXAMINERS

FEE SCHEDULE FOR PODIATRY

(Rev 050104)

Initial Licensure Fees

Note: If applying for a temporary permit, permanent licensure fee must accompany the temporary permit fee.

Profession		Form Of Payment	Payable To	Amount	Send To	Total
ALL APPLICANTS: FINGERPRINTS		Money Order	La. Department of Public Safety and Corrections	\$50.00	LSBME	\$50.00
For LSBME to return documents to applicant in U.S. by U.S. Certified Mail, Return Receipt Requested.		Check or Money Order	LSBME	\$2.55	LSBME	\$
RECIPROCITY	Podiatrist	Check or Money Order	LSBME	\$300.00	LSBME	\$
PODIATRIST	Podiatrist	Check or Money Order	LSBME	\$300.00	LSBME	\$
	Podiatrist Temporary Permit	Check or Money Order	LSBME	\$100.00	LSBME	\$
	Podiatrist Residency Training Permit	Check or Money Order	LSBME	\$50.00	LSBME	\$
TOTAL						\$

*Must Complete Waiver Form

NOTE: The LSBME will notify applicant if insufficient monies are remitted.

Renewal Fees¹

Medicine & Surgery/DO/INST due on or before the first (1 st) day of licensee's birth month.	
Podiatrists	Scheduled Renewal Fee \$200.00

¹ Fees are not prorated (i.e. License received mid-year fee payable in full, next annual renewal payable in full)

LOUISIANA STATE BOARD OF MEDICAL EXAMINERS

P. O. Box 30250, New Orleans, LA 70190-0250; Telephone: (504) 568-6820

Podiatry Initial Application for Licensure

(080106)

Check all that apply. Specify the purpose and discipline of licensure application. TYPE OR BLOCK PRINT ONLY.

Discipline applying for: _____ Podiatry

Application is based on: _____ First license _____ Licensure by endorsement _____ Reinstatement / Relicensure

Intended Location/Date in Louisiana: City _____ Date: _____

NAME: LAST		FIRST		MIDDLE		SUFFIX (SR, JR)	
SOCIAL SECURITY NUMBER		DRIVER'S LICENSE # & STATE		CONTROLLED SUBSTANCES PERMIT #'S <u>DEA:</u> _____ <u>STATE:</u> _____ <u>FED:</u> _____			
BUSINESS ADDRESS: *This address will appear on the LSBME website. **Renewal notices will be sent to this address. STREET & NO. (DO NOT USE P.O. BOX)				CITY		STATE	
ZIP + 4		COUNTY/PARISH		COUNTRY (IF NOT U.S.)		PHONE: _____ FAX: _____ EMAIL: _____	
HOME ADDRESS: STREET & NO.				CITY		STATE	
ZIP + 4		COUNTY/PARISH		COUNTRY (IF NOT U.S.)		PHONE: _____ CELL: _____ FAX: _____ EMAIL: _____	
PREFERRED MAILING ADDRESS: STREET & NO.				CITY		STATE	
ZIP + 4		COUNTY/PARISH		COUNTRY (IF NOT U.S.)		PHONE: _____ FAX: _____ EMAIL: _____	
<u>IDENTIFICATION:</u> RACE: _____ SEX: _____ WEIGHT: _____ HEIGHT: _____ EYES: _____ HAIR: _____ MARKS: _____ MARITAL STATUS: _____ SPOUSE'S FULL NAME: _____ PLACE OF BIRTH: _____ DATE OF BIRTH: _____ ARE YOU A U.S. CITIZEN? _____ IF NOT NATIVE BORN CITIZEN OF THE U.S. GIVE FOLLOWING INFORMATION: TYPE OF VISA: _____ IF NATURALIZED, CERTIFICATE #: _____ INS #: _____ PETITION # _____ DATE ISSUED: _____ DISTRICT COURT THROUGH WHICH ISSUED: _____ U.S. ACTIVE DUTY: BRANCH: _____ DATES SERVED: _____ TYPE DISCHARGE: _____ HAVE YOU EVER HELD ANY TYPE OF LICENSURE IN LOUISIANA? _____ IF YES, TYPE & #: _____							
<u>PERSONAL INTERVIEW</u>							
State the preferred location for personal interview with original credentials. Personal interview shall not be made until application is otherwise complete. If does not apply, mark "X" here: <input type="checkbox"/>							
<u>Podiatry</u> _____New Orleans _____Monroe							

Name (Printed or typed):

SS#:



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Statement of Legal Name

1. My name appears as follows on the following documents:

- a.) Medical/Professional diploma: _____
- b.) Internship and residency certificate(s): (give name and location of hospitals):

- c.) E.C.F.M.G. Certificate: _____
- d.) State License(s): (Identify State) _____
- e.) Specialty Board Certificate(s): (Identify Board) _____
- f.) Certificate of Naturalization, Declaration of Intention, Valid Visa: (Specify) _____

2. I am also known as: (list all names under which you are known) _____

My legal name and the name under which I will be known by the Louisiana State Board of Medical Examiners is: (if different from that which appears in No. 1a-1f above, a certified copy of your Marriage Certificate, Divorce Decree or Court Order must accompany this statement)

First Middle Last Suffix

I understand that the Louisiana State Board of Medical Examiners maintains all records in alphabetical order and that I will be listed alphabetically under my surname (last name) as stated in Item 1a of this Application.

Signature

Subscribed and sworn on this _____ day of _____, in the year _____.

Notary Public

My Commission Expires

SEAL

Name (Printed or typed):

SS#:

Education			Post Graduate Training <i>See attached "Unusual Circumstances"</i>		
High School			Hospital/Program		
City, State & Country, if not U.S.			City, State & Country, if not U.S.		
Month/Year Started	Month/Year Graduated		Month/Year Started	Month/Year Ended	Specialty
College/University			Hospital/Program		
City, State & Country, if not U.S.			City, State & Country, if not U.S.		
Month/Year Started	Month/ Year Ended	Degree	Month/Year Started	Month/Year Ended	Specialty
College/University			Hospital/Program		
City, State & Country, if not U.S.			City, State & Country, if not U.S.		
Month/Year Started	Month/ Year Ended	Degree	Month/Year Started	Month/Year Ended	Specialty
College/University			Hospital/Program		
City, State & Country, if not U.S.			City, State & Country, if not U.S.		
Month/Year Started	Month/ Year Ended	Degree	Month/Year Started	Month/Year Ended	Specialty
Podiatry School			Hospital/Program		
City, State & Country, if not U.S.			City, State & Country, if not U.S.		
Month/Year Started	Month/ Year Ended	Degree	Month/Year Started	Month/Year Ended	Specialty
Practice History and Non-Professional Activity (Do NOT include Training) Attach separate 8 ½ x 11 sheet if necessary. Account for ALL time not specified above, in chronological order, from High School to the present.					
From Month/Year	To Month/Year	City	State or Country	Employer or practice setting (Clinic, Hosp., Solo/Group, Etc.)	Specialty or Activity
/	/				
/	/				
/	/				
/	/				
/	/				
Have you ever taken any of the following written exams: PMLEXIS ____ Yes ____ No If yes, list name, location, date and result of each examination; failures must also be disclosed. Each examination agency must submit an original official Examination History Report directly to the LSBME. NOTE: Louisiana has a four time limit on all exams.					
Examination (indicate # of times taken)		Date		Result (Pass/Fail)	
Have you ever been licensed to practice in any state, territory, province, or country? ____ Yes ____ No If yes, list the State, License Number and Issue Date of license. Please include permanent, temporary, training, provisional, limited or permit. Verification is required for each. Attach separate 8 ½ x 11 sheet if necessary.					
State		License Number		Issue Date	

Name (Printed or typed):

SS#:



Louisiana State Board of Medical Examiners

P. O. Box 30250, New Orleans, LA 70190-0250

Telephone: (504) 568-6820

UNUSUAL CIRCUMSTANCES
FOR
PROFESSIONAL EDUCATION OR POST-GRADUATE TRAINING

Check Yes or No (for each Yes answer, an explanation is required):

Did you take a leave(s) of absence or break(s) from your medical/osteopathic/podiatry education? ☐ Yes ☐ No

Were you ever placed on probation? ☐ Yes ☐ No

Were you ever disciplined or placed under investigation? ☐ Yes ☐ No

Were any negative reports ever filed against you? ☐ Yes ☐ No

Were any limitations or special requirements imposed on you because of academic incompetence, disciplinary problems or for any other reason? ☐ Yes ☐ No

Please explain each "Yes" response from above:

Name (Printed or typed):

SS#:



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Third Party Authorization

I understand and acknowledge that the submission of an application to, as well as the acceptance or maintenance of, any license, permit, certificate and/or registration (hereinafter referred to as a "license") issued by the Louisiana State Board of Medical Examiners (the "Board") shall constitute and operate as a perpetual authorization by me to each educational institution at which I have matriculated, each state or federal agency to which I have applied for any license, permit, certificate and/or registration, each person, firm, corporation, clinic, office or institution by whom or with whom I have been employed in the practice of medicine or as an allied health professional, each physician or other health care practitioner whom I have consulted or seen for diagnosis or treatment and each professional organization or specialty board to which I have applied for membership, to disclose and release to the Board any and all information and documentation concerning me which the Board may deem material to the consideration of my initial application and during such period as I may hold or maintain a license. With respect to any such information or documentation, the submission of an application to or the acceptance or maintenance of a license from the Board shall equally constitute and operate as a consent by me to the disclosure and release of such information and documentation and as a waiver by me of any privilege or right of confidentiality which I would otherwise possess with respect thereto.

By submitting an application or accepting or maintaining a license issued by the Board, I shall be deemed to have given my consent to submit to physical or mental examinations if, when and in the manner so directed by the Board and to have waived all objections as to the admissibility or disclosure of findings, reports or recommendations pertaining thereto on the grounds of privileges provided by law. I acknowledge that the expense of any such examination shall be borne by me.

The submission of an application or the acceptance or maintenance of a license from the Board shall also constitute and operate as perpetual authorization and consent by me to the Board to disclose and release any information or documentation set forth in or submitted with my application, or which then or at any time thereafter may be obtained by the Board from other persons, firms, corporations, associations or governmental entities, to any person, firm, corporation, association or governmental entity having a lawful, legitimate and reasonable need therefor, including, without limitation, the medical and/or allied health professional licensing, permitting, certifying and/or registering authority of any state; the Federation of State Medical Boards of the United States; professional organizations, associations and societies; the American Medical Association and any component state, county or parish medical society, including but not limited to the Louisiana State Medical Society and component parish societies thereof; the American Osteopathic Association; the Louisiana Osteopathic Medical Association; the Federal Drug Enforcement Agency; the Louisiana Office of Narcotics and Dangerous Drugs, Office of Licensing and Registration, Department of Health and Hospitals; federal, state, county or parish and municipal health and law enforcement agencies and the Armed Services.

I understand that this authorization and consent is valid commencing on the date herein below subscribed and that such will remain in force and effect until and unless I withdraw my application for, or no longer possess or maintain, a license issued by the Board. I also acknowledge that a duplicate of this document may serve as an original.

Signature: _____
Full Name

****TO BE SIGNED IN THE PRESENCE OF A NOTARY**

Subscribed and sworn to before me this _____ day

of _____, 20 _____.

Notary Public

Seal

MY COMMISSION EXPIRES _____

Name (Printed or typed):

SS#:



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OATH OR AFFIRMATION

Answer the following questions (Yes answers must be explained in sworn affidavit **-AFFIDAVIT MUST BE TYPED!**)

	YES	NO
1. In the five years prior to this application, have you had any physical injury or disease or mental illness or impairment, which could reasonably be expected to affect your ability to practice medicine or other health profession?		
2. In the five years prior to this application, have you been addicted to or used in excess any drug or chemical substance including alcohol or treated through a drug or alcohol rehabilitation program?		
3. Have you ever, either as an adult or juvenile, been cited, arrested, charged, convicted or pled nolo contendere to, violation of any:		
a) State statute?		
b) Federal statute?		
4. Has your application for examination or license ever been rejected or denied?		
5. Have you ever failed a licensure/certification examination? If yes, how many times? _____		
6. Have you ever been denied membership in a state, county, or local professional society?		
7. Has your membership in a state, county, or local professional society ever been revoked, suspended, placed on probation, or restricted in any manner?		
8. Have you ever been denied, had suspended, revoked or restricted, or voluntarily relinquished, staff or clinical privileges in any hospital or other health care institution or organization?		
9. Have you had any malpractice claims filed, settled or adjudicated against you within the last five (5) years?		
10. Have you ever voluntarily surrendered, or did you have suspended, revoked or restricted, your narcotics controlled substances license or registration (state or federal)?		
11. Have you ever voluntarily surrendered, or did you have suspended, revoked, placed on probation, or restricted in any manner, any professional license issued by any licensing authority?		
12. Have you ever been the subject of any type of disciplinary action or inquiry by any licensing agency, hospital, institution, society, etc.?		
13. Have you ever agreed not to seek re-licensure in any licensing jurisdiction?		
14. Have you ever been, or are you currently in the process of being denied, terminated, suspended, refused, limited, placed on probation or placed under other disciplinary action with respect to your participation in any private, state, or federal health insurance program (e.g., Medicare, Medicaid)?		
15. Has any court determined you are currently in violation of a court's judgment or order for the support of dependent children?		

OATH OR AFFIRMATION OF APPLICANT

I HEREBY swear or affirm that all statements made and information provided in or with this application are true, correct and complete; that I am the person named in the credentials herewith presented and that I am the original and lawful possessor of such documents; that the photograph submitted to LSBME is a true likeness of me and that it was taken within the last 60 days; that in consideration of the issuance to me of a license/certificate to practice in Louisiana, I swear that I shall observe, abide by and uphold the laws of the State of Louisiana governing my practice and that I shall abstain from unethical, deceptive and fraudulent methods of practice and from immoral, unprofessional and unethical conduct, and that I shall not associate professionally with nor become a partner or employee of any person who resorts to such practices. I hereby agree that the violation of this oath shall constitute cause sufficient for the revocation of said license/certificate and surrender of the rights and privileges accorded me thereunder.

Signed _____ Full Name

Subscribed and sworn to before me this _____ day

of _____ YEAR _____

NOTARY PUBLIC

My commission expires _____

Name (Printed or typed):

SS#:



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Telephone: (504) 568-6820

CERTIFICATE OF DEAN/REGISTRAR

APPLICANT'S NAME

SOCIAL SECURITY NUMBER

Section 1: To Applicant—Complete Section 1 before a Notary. Forward this form to your Podiatry School.

Recent photograph

Passport quality photograph of applicant securely affixed. 2" x 2" clear, front view, full face without hat or dark glasses. Full-length photograph, black and white or computer-generated will not be accepted. Applicant is to sign name across bottom of photograph, partly on photograph and partly upon the page.

Notary is to affix seal directly on photograph.

***Affix Photograph
Here***

(Follow directions carefully.)

I certify that the photograph is a true likeness of _____ (Applicant).

On this the _____ Day of _____, 200_____

Notary Public

My commission expires _____

Section 2: To Dean/Registrar of Podiatry School

After completion of this form, return to Office of Licensure, Louisiana State Board of Medical Examiners, P. O. Box 30250, New Orleans, LA 70190-0250. DO NOT RETURN TO APPLICANT.

I hereby certify that _____

Whose photograph appears above, was awarded the degree of, or certificate in, _____

Dated _____ from this school.

Name of school/program

Signature of Dean/Registrar, Allied Program Chairman/Head

Address

Title

Date

Affix School Seal Here

Name (Printed or typed):

SS#:



Louisiana State Board of Medical Examiners

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VERIFICATION OF INTERNSHIP OR EQUIVALENT PROGRAM

Section 1: TO THE APPLICANT--In order to be eligible for licensure in Louisiana, the applicant must present proof of having completed at least one year of postgraduate clinical training in an internship or equivalent program accredited by a school or College of Podiatry and approved by the Board.

Complete the top section of this form and then forward it to the Director of Medical Education or Program Chairman for completion of the bottom section.

To Whom This May Concern at _____:

I am applying for license to practice medicine/podiatry in the state of Louisiana. This is your authorization to release all information in your files concerning me, favorable or otherwise, to the Louisiana State Board of Medical Examiners.

Print Or Type Your Full Name

Signature

Address

City, State and Zip Code

Section 2: To be completed by the Director of the Hospital or by the Director of Medical Education and returned directly to: Office of Licensure, Louisiana State Board of Medical Examiners, P. O. Box 30250, New Orleans, LA 70190-0250. This form is NOT to be returned to the Applicant.

Re: _____
(Applicant's name)

This to verify that the records of this institution indicate that the referenced physician/podiatrist served an Internship or Equivalent Program as follows:

Dates of Internship (PGY-1): Start Date: _____; End Date: _____

Type of Internship served: _____ Transitional; _____ Rotating; _____ Categorical (specify specialty) _____

Did the physician/podiatrist successfully complete the Internship? _____ Yes; _____ No.

Please explain

Date: _____

Signed: _____

Title: _____

(Seal of Institution)

Name of Institution: _____

Address: _____

Name (Printed or typed):

SS#:



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****To be completed if applying based on reciprocity****

VERIFICATION / ENDORSEMENT

Section 1: To Applicant— Complete Section 1 of this form and forward it to the licensing agency of each state in which you have ever obtained licensure/certification, whether permanent or temporary. If necessary, this form may be duplicated.

I hereby authorize the licensing agency of the State of _____ to release all information on file concerning me, favorable or otherwise, to the Louisiana State Board of Medical Examiners.

TYPE OR PRINT YOUR FULL NAME

SIGNATURE

LICENSE NUMBER AND DATE ISSUED

ADDRESS

SOCIAL SECURITY NUMBER

CITY, STATE, ZIP CODE

Section 2: THE SECTION BELOW IS TO BE COMPLETED BY THE VERIFYING/ENDORING STATE and returned to the Louisiana State Board of Medical Examiners, P.O. Box 30250, New Orleans, LA 70190-0250. This form is NOT to be returned to the Applicant.

A. This is to certify that the records of the licensing Board of the State of _____ indicate that the above-named individual was issued license/certificate No. _____ dated _____ on the basis of written examination (state name of examination) _____; reciprocity with the state of _____; other basis (please name) _____.

B. If State Board Examination, provide statement of grades or attach hereto.

C. Provide the following:

1. Is this license/certificate current? ☐ Yes ☐ No ☐ Cannot Divulge
2. Is this license/certificate in good standing? ☐ Yes ☐ No ☐ Cannot Divulge
3. Has this individual ever been warned or reprimanded? ☐ Yes ☐ No ☐ Cannot Divulge
4. Has this individual license/certificate ever been revoked? ☐ Yes ☐ No ☐ Cannot Divulge
5. Has this individual license/certificate ever been suspended? ☐ Yes ☐ No ☐ Cannot Divulge
6. Has this individual license/certificate ever been placed on probation? ☐ Yes ☐ No ☐ Cannot Divulge
7. Has this individual license/certificate ever been restricted in any manner? ☐ Yes ☐ No ☐ Cannot Divulge
8. Has this individual ever had any charges filed against him/her? ☐ Yes ☐ No ☐ Cannot Divulge
9. Do you know of any information that may be a discredit to this person? ☐ Yes ☐ No ☐ Cannot Divulge
10. Do your files indicate any derogatory information whatsoever? ☐ Yes ☐ No ☐ Cannot Divulge

REMARKS _____

Date

Signature

Title

BOARD SEAL

Name and address of licensing agency

NOTE TO BOARD COMPLETING THIS FORM: If answer to 1 or 2 is "No", or 3 through 10 is "Yes", explain and attach certified copies of pertinent material (i.e., Notice of Hearing, Final Decision, Consent Order/Agreement, etc.).